APPENDIX A — N.Y. PUBLIC HEALTH LAW § 3600

The Legislature hereby finds and declares that the provision of high quality home care services to residents of New York State is a priority concern. Expanding these services to make them available throughout the state as a viable part of the health care system and as an alternative to institutional care should be a primary focus of the state's actions.

Home health care has only recently been recognized legislatively as an integral part of the health care delivery system and has proven to have an important and valuable role in patient care. *The certified home health agencies render a coordinated array of services to patients in their homes, thereby avoiding prolonged institutionalization, concomitant high costs and association adverse social and medical implications.*

The legislature intends that there be a public commitment to the appropriate provision and expansion of services rendered to the residents of the state by certified home health agencies, to the maintenance of a consistently high level of services by all home care services agencies, to the central collection and public accessibility of information concerning all organized home care services, and to the adequate regulation and coordination of existing home care services.

N.Y. Public Health Law § 3600 (emphasis added).

APPENDIX B — 62 FED. REG. 33158, 33185

There is no definition of "actual charge" in the Medicare statute, and some would argue that "actual charge" means whatever amount the physician, supplier, or other person who furnishes the service states it is, regardless of whether he, she, or it charges the beneficiary or the beneficiary's private plan that amount or makes any effort to collect it. In fact, because of the prevalence of participation in private plans, the physician, supplier, or other person might never charge or expect to collect this amount from anyone.

APPENDIX C — 62 FED. REG. 47182-01 (SEP. 8, 1997)

Section 1001.701, Excessive claims or furnishing of unnecessary or substandard items or services

In an effort to more clearly define the scope of an action under section 1128(b)(6) of the act, we are proposing to revise paragraph (a)(1) of this section to further clarify to whom an individual's or entity's excess charges or costs apply. The revised language would indicate that the OIG may exclude an individual or entity that has submitted, or caused to be submitted, bills or requests for Medicare or State health care program payments that contain charges or costs that are substantially in excess of their usual charges or costs for items or services furnished to any of their customers, clients or patients. We specifically welcome comments on this OIG policy clarification.

APPENDIX D — 63 FED. REG. 46676 (SEP. 2, 1998)

Section 1001.701, Excessive Claims or Furnishing of Unnecessary or Substandard Items or Services

Comment: In an effort to more clearly define the scope of an action under *section 1128(b)(6) of the Act*, we proposed to revise §1001.701(a)(1) to further clarify to whom an individual's or entity's excess charges or costs apply. Many commenters strongly objected to what they believed was the OIG's setting of Medicare payment policy (for bills submitted on the basis of costs or charges) at the best price charged to any payer. Specifically, the proposed language addressed possible exclusion of providers that have "submitted, or caused to be submitted, bills or request for Medicare, Medicaid and all other Federal health care program payments that contain charges or costs that are substantially in excess of their usual charges or costs for items or services furnished to any of their customers, clients or patients." Many of the commenters indicated that this proposed revision would create excessive administrative and billing difficulties that would require a comprehensive and consistent review of charges to all customers. Further commenters stated that this proposal would have substantive implications for providers who work with managed care programs, discouraging providers from entering into these discounted rate arrangements or possibly forcing physicians participating in these programs to increase their contract rates in an effort to recover what may constitute a loss on Medicare program claims. In addition, commenters indicated that the proposed

revision fails to take into account that most physician payments under Medicare are now determined by a resource-based relative value scale system.

Response: Many commenters misunderstood our proposal. The proposed rule intended to subject those who submit bills based on costs or charges to liability for exclusion if they presented bills for amounts "substantially in excess" of lowest prices charged any customer. Nevertheless, persuasive arguments have been raised, and we are withdrawing our proposed modification to §1001.701 at this time. We have become convinced that the prohibitions of *section 1128(b)(6)(A) of the Act* have very limited applicability with respect to the current Medicare reimbursement system. The recently-enacted Balanced Budget Act of 1997, Public Law 105-33, either directly mandates prospective payment or provides authority for the Secretary to develop additional fee schedules to replace almost all existing cost or charged-based reimbursement methodologies. The purpose of fee schedules is to bring Medicare reimbursement more in line with market rates. As fee schedules are implemented, providers may have less incentive and less opportunity to claim Medicare payment that is substantially in excess of their usual charges. Therefore, we would expect this statutory authority to have declining relevance within the Medicare reimbursement system. *Moreover, the statute contains the undefined term "substantially in excess," which makes enforcement action difficult. As such, we now believe that modifying the definition of "usual charges" will have very little impact.*

APPENDIX E — EXCERPT FROM DECISION OF ADMIN. OF DEP'T OF HEALTH, EDUC. AND WELFARE, DATED MAY 28, 1971

> The effect of the Connecticut provision is to place a ceiling on the amount which can be paid to a participating hospital for inpatient care. *Moreover, . . . the ceiling is one which will not, in many cases, reimburse the hospital for the actual costs of providing care to Title XIX patients, based as it is on the lowest published charge, and not on a system of average charges.* Consequently, the effect of the ceiling may very well be to shift part of the cost of providing such care to Title XIX patients onto other paying patients, or the provision of substandard services to Title XIX patients.

See Decision of Admin. of Dep't of Health, Educ. and Welfare, ~~dated~~ May 28, 1971, reproduced at R. 200; also reported at CCH Medicare/Medicaid Guide, ¶ 26,304.